2999 Regent Street, Suite 325, Berkeley, CA 94705
96 Davis Road, Suite 2, Orinda, CA 94563
(925) 438-1100
www.eastbaypediatrics.com

Patient Information Form

Child's Name:		DOB:	

Male	Female	Birth Weight	

Sibling(s)

Name:		DOB:	
Name:		DOB:	
Name:		DOB	

Address_____ _____
Street City/zip

Parent's Name:_____ Parent's Name:_____
SS# _____ SS# _____
DOB_____/_____/_____ DOB ____/____/____
Address (if different than above): Address (if different than above):
_____ _____
_____ _____

Confidential Communication Preference. **Please circle**: Home Phone / Cell Phone / Text / Email

Primary Email _____

Home Phone #_____ Home Phone # _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Work Phone # _____ Work Phone # _____

Cell Phone # _____ Cell Phone # _____

I acknowledge receipt of: East Bay Pediatrics Medical Group Financial and Billing Policies & East Bay Pediatrics Medical Group Notice of Privacy Practices

_____ _____
Signature of Parent/Guardian ***Print Name***
_____ ***Primary language spoken: English____ Other_____***
Date